Medi-Cal Program Guide (MPG) Special Notice 08-10

September 25, 2008

Subject **COUNTY MEDICAL SERVICES (CMS) LAWSUIT RETRO#2 CASE PROCESSING**

Effective Date September 16, 2008

Reference County of San Diego, Superior Court Case No. GIC841583 - Class Action Lawsuit regarding CMS denials occurring during the period January 24, 2004 through November 30, 2007 due to excess income.

Purpose The purpose of this Special Notice (SN) is to provide instructions for processing cases affected by this Lawsuit.

Background On January 24, 2005, a class action lawsuit was filed against the County of San Diego in San Diego Superior Court. The lawsuit was certified as a class action on behalf of individuals who:

- since January 24, 2004 through November 30, 2007, were denied eligibility for the CMS program solely based on the income limits in effect at that time; and
- thereafter paid for their own care and/or incurred debt to health care providers for such care.

On July 16, 2008, the court approved new income eligibility standards for the CMS program which became effective July 1, 2008.

Additionally, the court required the County to mail a Claim Form Packet to all persons who were denied CMS based solely on excess income on or after January 24, 2004 through November 30, 2007. The Claim Form Packet consists of:

- Notice of Judgment in a Class Action (Attachments A&B)
- CMS Class Action Claim Form (Attachments C&D)

Continued on next page

Background *(continued)*

- Application for CMS Hardship (CMS-01L/CMS-01L (SP)) (Attachments E1&E2 and F1&F2)
- CMS Lawsuit Claimant Authorization for Release of Information
- (Attachments G&H)
- Information Notice: Liens/Repayment (CMS-109/CMS-109 (SP)) (Attachments I&J)
- Reimbursement Agreement (CMS-106/CMS-106 (SP)) (Attachments K&L)
- Credit Check Authorization (CMS-99L/CMS-99L (SP)) (Attachments M&N)

A re-determination of income eligibility for CMS based on the new CMS income standards shall be completed for individuals who return a claim form and any other required documentation and are determined to meet the class member definition.

On September 16, 2008, the County conducted a mass mailing of the Claim Form Packets to approximately 10,000 potential class members.

Class Member Definition

As outlined in the court order, a CMS Lawsuit Class Member is an individual who, since January 24, 2004 through November 30, 2007, has been denied eligibility for CMS based solely on the income limits used by the County at that time, and who thereafter paid for their own health care and/or incurred a debt to health care providers for such care.

Furthermore, to be eligible as a class member, the patient must submit a completed claim form and must answer YES to both Questions 1 and 2 as well as answer YES to either or both Questions 3 and 4.

Case Handling Procedures

Cases meeting the criteria set forth in the court order shall be reviewed by a team of workers under the direct supervision of the CMS Retro Program Specialist (PS). This team will herein after be referred to as the Retro Team.

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Case Handling Procedures *(continued)*

There are three different application types: Hospital cases (DSS), Clinic cases (DHS), and Emergency Room Treat & Release cases (ER). Each application type requires a different case handling process.

- **DSS** cases are Hospital Outstation Services (HOS) cases with WCDS or CalWIN history. Upon receipt of the completed Lawsuit Claim Form from the patient, these cases will be requested from Record Library.
- **DHS** cases are Clinic Outstation Services (COS) cases set up much like a pencil file, tracked by patient name and Social Security number only. Active clinic cases are held at the clinic site and will need to be requested upon receipt of the completed Lawsuit Claim Form from the patient. It is anticipated that the majority of the clinic cases; however, remain in a denied status held at the off-site storage facility, Iron Mountain. These cases will be requested from Iron Mountain upon receipt of the completed Lawsuit Claim Form from the patient.
- **ER** cases consist only of the CMS-35 & CMS-36 and are held with the Administrative Services Organization (ASO), tracked by patient Social Security number. Upon receipt of the completed Lawsuit Claim Form from the patient, these forms will be requested from the ASO.

Required Actions

Claimants shall be given 60 days to submit their completed Lawsuit Claim Forms and all documents needed to complete the eligibility determination and reimbursement process.

When a claim form is received, it shall first be reviewed to determine whether the claimant meets the criteria of an eligible class member, as described above in "Class Member Definition". If class member criteria are not met the claim shall be denied. If class member criteria are met, the claim will then be reviewed for retro income eligibility. The claimant shall be notified of actions taken as described below in "Notification Requirements".

Continued on next page

Required Actions *(continued)*

Class Action Lawsuit claimants will be required to provide proof of citizenship as a condition of eligibility as outlined in the MPG, Article A, Section 4.

When a completed claim form is received from an eligible class member without all necessary documents/verifications, and a 2006 Retro (Retro 1) claim exists, the Retro Team worker will review the 2006 Retro claims records to attempt to obtain the missing documentation. If the necessary verifications are not located in the Retro 1 records or a Retro 1 claim does not exist, the Retro Team worker will use form CMS-16L/CMS-16L (SP) (Attachment O&P), as the initial request for verifications. If the claimant did not return any required documents from the Claim Form Packet, the missing documents shall also be listed on the CMS-16L/CMS-16L (SP).

The CMS-16L/CMS-16L (SP) informs the claimant that they have 10 days from the date of the letter to provide the documents/verifications needed to complete the eligibility determination and process their claim. If the documents/verifications are not received, the Retro Team will send Form CMS-22L/CMS-22L (SP) (Attachment Q&R) as the second request, allowing 10 more days before denial of the claim. The CMS-22L/CMS-22L (SP) deadline may be extended if any of the criteria outlined in MPG 4-13-3 is applicable.

All eligible class members will have their application reevaluated based on the increased Federal Poverty Level (FPL) income limits in effect at the time the claimant applied for CMS.

If claimant's income is at or below 165% of the FPL in effect at the time the claimant applied for CMS, as shown on the table below, the claimant will be approved with a zero share of cost for the appropriate certification period, as otherwise eligible.

If claimant's income is over 165% up to and including 350% of the FPL in effect at the time the claimant applied for CMS, as shown on the table below, the hardship application will be processed. The claimant may be eligible to CMS with or without a share of cost for the appropriate certification period, as otherwise eligible.

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Required Actions *(continued)*

Eligibility Period	165% FPL		350% FPL	
	1 Adult	Married Couple	1 Adult	Married Couple
1/24/04 thru 6/30/04	1234	1667	2618	3535
7/1/04 thru 6/30/05	1280	1718	2716	3644
7/1/05 thru 6/30/06	1317	1764	2793	3742
7/1/06 thru 6/30/07	1348	1815	2860	3850
7/1/07 thru 6/30/08	1404	1883	2979	3994

When processing the hardship application, refer to MPG Article A, Section 13. Use the dollar amounts as shown on the Maximum Allowable Expenses (MAE) table (Attachment S) or the applicant's self-declared expenses, whichever is the lesser amount.

Re-determinations of income eligibility for CMS that result in ineligibility shall be denied within 45 days of receipt of the completed claim form and/or hardship application, and all supporting documentation.

Re-determinations of income eligibility to CMS that result in either reimbursement entitlement to the claimant, and/or payment to providers to whom claimant remains indebted for services or medications provided shall be paid within 60 days of review of the claim form and/or hardship application.

All returned mail will be logged in to the CMS Retro Team Tracking Log, reviewed, and resent whenever possible. Retro Team will clear all available systems (CalWIN, MEDS, IDX, and AuthMED) for new address/phone number. If a new address is found, the Retro Team will add the new address to the CMS Retro Team Tracking Log, resend the Claim Form Packet. Claim Form Packets sent out a second time will be tracked for return within 60 days from the second mailing date.

Notification Requirements

If it is determined that the claimant does not meet the class member definition set forth by the court, the Retro Team shall send Notice of Action CMS-39LDC/CMS-39LDC (SP) (Attachment T&U) to all persons determined ineligible as a class member.

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Notification Requirements *(continued)*

Upon completion of the eligibility re-determination, Notice of Action CMS-39LA/CMS-39LA (SP) (Attachment V&W) shall be sent to all persons who meet the class member definition and have otherwise been determined eligible to CMS. Notice of Action CMS-39LD/CMS-39LD (SP) (Attachment X&Y) shall be sent to all persons who meet the class member definition but have otherwise been determined ineligible to CMS.

The Retro Team worker shall give the "**Notice of Privacy Practices**" to all individuals who are certified or recertified for CMS as required under the Health Insurance Portability and Accountability Act (HIPAA). The worker must document on the Retro Team Narrative (Attachment Z) the date this notice was given.

CMS enrollment is not automated for this retro activity; therefore, the Retro Team worker must send form CMS-4 to the ASO to update eligibility information on IDX. A special notation shall be made on each form to denote this as a Retro 2 case. A new Eligibility Site, 2999, has been created for use in IDX for Retro 2 and will be used for all approvals. This unique Eligibility Site will be used for tracking eligibility and payments for the patients approved under this project.

Tracking Log

A Tracking Log has been created to record the disposition of each Lawsuit Claim Form mailed. The Retro Team shall record the following information on this Tracking Log:

- Class member determinations
- Eligibility approvals
- Eligibility denials
- Total net countable income used in determinations that result in denial due to excess income
- Returned mail dispositions

Retro Team Narrative and Documentation Retention

A CMS Retro Team Narrative (Attachment Z) has been developed for use with claims described in this Special Notice. All case actions related to the Lawsuit shall be fully narrated in the case record by the Retro Team worker and all documentation, including returned mail, shall be retained for a period of 7 years.

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Referral Toll-free Number

A toll free phone number has been established for general information inquiries. The number is 1-800-587-8118. Callers will be directed through a system of prompts to leave their name and phone number so that a Retro Team member may return their call within one business day.

Denial of Class Member Status Administrative Reviews

Request for Administrative Review regarding denial of class member status will be reviewed and a determination will be made by the CMS Retro Program Specialist (PS). If the claimant is dissatisfied with the CMS Retro PS's review decision, the claimant may file for a County Administrative Hearing.

Cases Involved

Appeals regarding denial of class member status procedures apply only to those individuals who have returned a completed Lawsuit Claim Form and been determined to be excluded from consideration as a member of the CMS Class Action Lawsuit. The affected persons will have been notified of the denial with Form CMS-39LD issued by the CMS Retro Team. Form CMS-39LD informs the patient of their right to request an Administrative Review, in writing or by phone, within 14 days from the date of the notice.

Good Cause for Late Filing

Any requests for an Administrative Review regarding denial of class member status received more than 14 days from the date of the CMS-39LD will be evaluated for good cause following the parameters outlined in MPG Article A, Section 12.4.

Recording the Request

The CMS Retro PS will complete the Class Member Appeal Log (Attachment AA) upon receipt of the request for appeal regarding denial of class member status. The date the request is received shall be the file date.

Conducting the Denial of Class Member Status Administrative Review

The CMS Retro PS will obtain the patient's lawsuit packet from the lawsuit files held with the Retro Team. The packet will be thoroughly reviewed and the patient will be contacted by phone. The Lawsuit Claim Form will be reviewed with the patient to determine if the form

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Conducting the Denial of Class Member Status Administrative Review *(continued)*

was properly completed. No corrections will be made on the form without patient's initials. Any changes will be fully narrated and entered into the patient's lawsuit case record. IDX claims will also be reviewed, as well as the medical expense verifications submitted by the patient with their claim form.

Status Determination and Appeal Review Decision

Once all information has been thoroughly reviewed, a determination will be made as to whether the patient meets the definition of a Lawsuit Class Member and a written decision will be issued. A copy of the decision will be attached to the patient's lawsuit packet. The written decision will provide an explanation of the basis for the decision and will detail the verifications and /or information used in the decision making process. The CMS Retro PS shall record the date of the written decision on the Class Member Appeals Log and the Retro Team Tracking Log will be updated to reflect any changes, as applicable.

If the Class Member denial is determined to be incorrect, the packet will be returned to the Retro Team for an immediate eligibility determination.

If it is determined that the Class Member denial was correct, the lawsuit packet will be returned to files with a copy of the decision attached as a permanent part of the lawsuit case record.

Appeals Impact

There is no change from the current appeals process for all issues regarding eligibility.

CMS Information Technology (IT) System

All CMS Retro 2 Claims and associated Hardship applications will be evaluated manually.

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Automation Impact None

Forms Impact The following forms were created or modified for use specifically for Retro Team case processing:

Attachment	Title and Form Number
A	Notice of Judgment in a Class Action
B	Notice of Judgment in a Class Action (SP)
C	CMS Class Action Claim Form
D	CMS Class Action Claim Form (SP)
E1-E2	Application for CMS Hardship - Page 1,2 – CMS-01L
F1-F2	Application for CMS Hardship - Page 1,2 – CMS-01L (SP)
G	CMS Lawsuit Claimant Authorization for Release of Information
H	CMS Lawsuit Claimant Authorization for Release of Information (SP)
I	Information Notice: Liens/Repayment (CMS-109)
J	Information Notice: Liens/Repayment (CMS-109 (SP))
K	CMS Reimbursement Agreement (CMS-106L)
L	CMS Reimbursement Agreement (CMS-106L (SP))

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Forms Impact
(continued)

M	Credit Check Authorization (CMS-99L)
N	Credit Check Authorization (CMS-99L (SP))
O	1st Request for Verifications (CMS-16L)
P	1st Request for Verifications (CMS-16L (SP))
Q	2nd Request for Verifications (CMS-22L)
R	2nd Request for Verifications (CMS-22L) (SP))
S	Maximum Allowable Expenses (MAE) Table
T	Denial, Class Member (CMS-39LDC)
U	Denial, Class Member (CMS-39LDC (SP))
V	Class Member Eligibility Approval (CMS-39LA)
W	CMS-39LA Class Member Eligibility Approval (CMS-39LA (SP))
X	Class Member Eligibility Denial (CMS-39LD)
Y	Class Member Eligibility Denial (CMS-39LD (SP))
Z	CMS Retro Team Narrative
AA	Class Member Appeals Log

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Quality Assurance Impact

None. All eligibility determinations will be reviewed by the CMS Retro Program Specialist prior to IDX notification.

Manager Approval

Dann Crawford, Assistant Deputy Director
Medi-Cal, CMS, General Relief and CAPI Program Administration
Strategic Planning & Operational Support Division

Manager Contact

Susan Battisti
(858) 492-2283

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF SAN DIEGO
CENTRAL DIVISION

RENEE ALFORD, ET AL.,
Petitioners/Plaintiffs

v.

COUNTY OF SAN DIEGO, ET AL.,
Respondents/Defendants

Case No. GIC841583

NOTICE OF NEW INCOME ELIGIBILITY STANDARD FOR COUNTY MEDICAL SERVICES (CMS)

PLEASE READ THIS NOTICE CAREFULLY
YOUR LEGAL RIGHTS MAY BE AFFECTED.
YOU ARE NOT BEING SUED.

If you were denied eligibility for County Medical Services (CMS) between January 24, 2004 and November 30, 2007 because your income was higher than the CMS income limit, you may be entitled to:

1. **Be repaid by the County for healthcare costs or medications you paid for, and/or**
2. **Have the County pay any outstanding debts you still have for such healthcare.**

NATURE AND STATUS OF THE LAWSUIT

On January 24, 2005, five San Diego County residents filed a class action lawsuit against the County of San Diego in San Diego Superior Court. The lawsuit was certified as a class action on behalf of individuals who, during the period of January 24, 2004 through November 30, 2007, were denied eligibility for CMS because their income exceeded the limits used by the County at that time. The County has now established new income eligibility standards for the CMS program, and the court approved them.

CLAIM FORM REGARDING DENIAL OF CMS

If you believe you were improperly denied eligibility for CMS please complete the enclosed Claim Form Packet ((1) CMS Class Action Claim Form, (2) Application for CMS Hardship, (3) CMS Lawsuit Claimant Authorization for Release of Information, (4) Agreement to Reimburse the County of San Diego, and (5) Credit Check Authorization) and mail the completed Claim Form Packet and supporting documentation to:

County Medical Services
P.O. Box 85524
San Diego, CA 92186-5524

The completed Claim Form Packet must be received by County Medical Services by November 15, 2008.

If you are unable to locate all supporting documentation, submit the completed Claim Form Packet by the due date listed above and you will be given additional time to provide the remaining supporting documentation.

If you need more information regarding the class action lawsuit, please visit the CMS website at http://www2.sdcounty.ca.gov/hhsa/ServiceCategoryDetails.asp?ServiceAreaID=289, or call 1-800-587-8118 for more information or assistance.

You may be represented by class counsel (Western Center on Law and Poverty) for this lawsuit about the CMS income limits. They may be able to respond to questions about your eligibility. You can contact them toll-free at 1-800-405-8795 or by mail at:

Western Center on Law and Poverty
Attn: CMS Lawsuit
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

CORTE SUPERIOR DE EL ESTADO DE CALIFORNIA
CONDADO DE SAN DIEGO
DIVISION CENTRAL

RENEE ALFORD, ET AL.,
Peticionario/Demandante

Caso No. GIC841583

v.

NOTIFICACION DEL NUEVO NIVEL DE ELEGIBILIDAD DE INGRESO PARA EL PROGRAMA COUNTY MEDICAL SERVICES (CMS)

COUNTY OF SAN DIEGO, ET AL.,
Respondedor/Demandado

FAVOR DE LEER ESTA NOTIFICACION CUIDADOSAMENTE
SUS DERECHOS LEGALES PODRIAN SER AFECTADOS.
USTED NO ESTA SIENDO DEMANDADO.

Si se le negó la elegibilidad para el programa County Medical Services (CMS) entre la fecha de Enero 24, 2004 y Noviembre 30, 2007 debido a que su ingreso mensual excedía el límite de ingreso del programa CMS, puede que tenga derecho a:

1. **Ser reembolsado por el Condado por gastos de servicios médicos o gastos de medicinas que usted pago, y/o**
2. **Hacer que el Condado pague cualquier deuda pendiente que usted todavía tiene para tal servicio medico.**

CARACTER Y ESTADO LEGAL DEL JUICIO

En enero 24, 2005, cinco residentes del Condado de San Diego entablaron una demanda colectiva en contra de el Condado de San Diego en la Corte Superior de San Diego. El juicio ha sido certificado como una demanda colectiva en beneficio de individuos que, entre Enero 24, 2004 a Noviembre 30, 2007, fueron negados elegibilidad al programa CMS debido a que el ingreso mensual excedía el límite de ingreso del programa CMS que estaba en efecto durante ese tiempo. El Condado ha estabilizado un nuevo nivel de ingreso para la elegibilidad al programa CMS, y la Corte lo ha aprobado.

FORMA DE RECLAMO REFERENTE A LA NEGACION DE CMS

Si usted cree que le fue negada la elegibilidad al programa de CMS incorrectamente, favor de llenar el Paquete de Formas de Reclamo que se adjunta (1) CMS Forma de Reclamo, (2) Solicitud por Circunstancia Extrema de CMS (3) Autorización para Proporcionar Información para CMS Reclamante de la Demanda Colectiva (4) Acuerdo de Reembolso al Condado de San Diego y (5) Autorización a Revisar Crédito y mandar por correo el Paquete de Formas de Reclamo con documentación de apoyo a:

County Medical Services
P.O. Box 85524
San Diego, CA 92186-5524

El Paquete de Formas de Reclamo llenado, debe de ser recibido por County Medical Services (CMS) para Noviembre 15, 2008.

Si usted no puede localizar toda la documentación de apoyo, mande el Paquete de Formas de Reclamo para la fecha mencionada arriba y se le dará tiempo adicional para proveer el resto de documentación de apoyo.

Si usted necesita más información sobre esta demanda colectiva, favor de visitar la pagina de Web de CMS a http://www2.sdcounty.ca.gov/hhsa/ServiceCategoryDetailsasp?ServiceAreaID=289, o llamar para más información o asistencia a 1-800-587-8118.

Usted puede ser representado por abogados (Western Center on Law and Poverty) de esta demanda sobre el limite de ingresos de CMS. Ellos pueden responder a preguntas sobre su elegibilidad. Usted puede contactarlos sin costo al 1-800-405-8795 o por correo a:

Western Center on Law and Poverty
Attn: CMS Lawsuit
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

CMS CLASS ACTION CLAIM FORM

INSTRUCTIONS:

- Submit this claim form only if you answer "yes" to both questions 1 and 2.
- If your answer to both questions 1 and 2 is "yes", complete, sign and date this claim form and submit it with supporting documentation by November 15, 2008. If you are unable to locate all supporting documentation, submit the completed Claim Form by the due date listed above and you will be given additional time to provide the remaining supporting documentation.
- If you have questions, or need assistance, contact the County for at 1-800-587-8118 or the Consumer Center for Health, Education and Advocacy at the Legal Aid Society of San Diego at (877) 734-3258.

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1. Yes □ No □ Were you denied eligibility for the CMS program during the period of January 24, 2004 through November 30, 2007, only because your monthly income was higher than the CMS eligibility income cap then in effect?

2. Yes □ No □ If you answered "yes" to #1 , did you receive any health care services or medications from a doctor, clinic, hospital, or other health care provider in San Diego County in the month you applied or afterwards, up to and including November 30, 2007?

If the Answer to <u>either</u> Question #1 or #2 is NO, do not complete or return this claim form.
If the Answers to both Questions #1 and #2 are YES, then complete the following:

3. Yes □ No □ As a result of having been denied eligibility for CMS, did you pay for all or part of those health care services or medications?

4. Yes □ No □ As a result of having been denied eligibility for CMS, do you still owe the provider or a collection agency for all or part of those health care services or medications?

If your answers to both Questions #3 and #4 above are NO, do not complete or return this claim form.
If your answer to either Question #3 or #4 above is YES, complete the following and return this claim form in the pre-addressed postage paid envelope provided:

5. Tell us about the health care services and/or medication(s) you received, where you received them and how much, if anything, you have paid toward the bill(s), and how much you still owe.

Date of Service	Name of Doctor, Clinic, Hospital, other Health Care Provider, or pharmacy	Provider Address/Phone Number	Total Payment(s) Made	Amount you still owe
			$	
			$	
			$	
			$	

Enclose <u>COPIES</u> of unpaid bills from health care providers and collection agencies. Do <u>NOT</u> submit your originals.

Please enclose proof of payment (such as receipts, letters, cancelled checks, or credit card statements) for each bill listed above that you have made payment on.

6. Tell us who you are.

Name_____

Social Security #_____

Phone Number (where you can receive a message)_____

Mailing Address: Street Address, ZIP Code, State _____

_____

<u>ALL APPLICANTS MUST ENCLOSE PROOF OF US CITIZENSHIP.</u>

Please check one of the following:

_____ I have read the foregoing questions and answers. I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct to the best of my knowledge. **{OR}**

_____ I am unable to read the foregoing questions and answers but someone has read them to me in my native language. I declare under penalty of perjury, under the laws of the State of California, that the answers that were read to me are true and correct to the best of my knowledge.

Executed this _____ day of _____, 2008, at _____ [City, State]

Signed by: _____

Translator Signature (if any): _____

FORMA DE RECLAMO REFERENTE A UNA DEMANDA COLECTIVA

INSTRUCCIONES:

- Presente esta forma solamente si usted contesto "si" a ambas preguntas numero 1 y 2.
- Si su respuesta es "si" a las dos preguntas 1 y 2, complete, firme y ponga fecha a esta forma de reclamo y regrese con todos los documentos mencionados abajo a mas tardar para Noviembre 15, 2008. Si le es incapaz de localizar todos los documentos, presente esta forma completa y firmada para la fecha indicado arriba y se le dará el tiempo adicional para proporcionar los documentos que quedan.
- Si usted tiene preguntas, comunicarse con el Condado para pedir asistencia al 1-800-587-8118 o con El Centro del Consumidor Para Educación y Defensa de la Sociedad Ayuda Legal de San Diego al (877) 734-3258 para pedir ayuda.

1. Si □ No □ ¿Le fue negada la elegibilidad al programa de CMS durante el periodo de Enero 24, 2004 a Noviembre 30, 2007, por la razón de que su ingreso neto mensual era mas alto que el limite de ingreso del programa CMS que se uso entonces?

2. Si □ No □ Si contesto "si" a la pregunta #1, ¿Recibió usted servicios médicos o medicinas de un doctor, clínica, hospital u otro proveedor de cuidado de salud en el Condado de San Diego en el mes que usted aplico o después, hasta y incluyendo Noviembre 30, 2007?

Si la respuesta a cualquiera de las preguntas #1 o #2 es NO, no complete y regrese esta forma de reclamo.
Si la respuesta a AMBAS preguntas #1 y #2 son SI, entonces, complete lo siguiente:

3. Si □ No □ Como resultado de haber sido negada su elegibilidad para CMS, ¿Tuvo que pagar por todo o parte de sus servicios médicos o medicinas?

4. Si □ No □ Como resultado de haber sido negada su elegibilidad para CMS, ¿Debe todavía dinero a su proveedor o a alguna agencia de colecciones por todo o parte de los servicios médicos o medicinas?

Si la respuesta a AMBAS preguntas #3 y #4 son NO, no complete esta forma de reclamo y regresela.
Si la respuesta a alguna de las preguntas #3 o #4 es SI, entonces complete lo siguiente y regrese esta forma de reclamo en el sobre prepagado que esta incluido..

5. Díganos sobre los servicios y/o medicina(s) usted recibió y donde las recibió u cuanto, si hay cantidad, usted ha pagad o y cuanto usted todavía debe para pagar:

Fecha de Servicio	Nombre del Doctor, Clínica, Hospital u otro Proveedor de Cuidado de Salud	Dirección/Numero de teléfono del proveedor	Cantidad que Pago en Total	Cantidad que todavía se debe
			$	
			$	
			$	

Favor de incluir <u>COPIAS</u> de cobros aún sin pagar de proveedores médicos y agencias de colección. <u>NO</u> mande los originales.

Favor de incluir prueba del pago (como recibos, carta, cheques anulados, o estado de tarjeta de crédito) para cada cobro anotado arriba que usted a hecho un pago.

7. Díganos quien es usted:

Nombre_____

Numero de Seguro Social_____

Teléfono (donde pueda recibir mensajes)_____

Dirección Completa: Número, Calle, Código Postal, Estado _____

_____

TODO SOLICITANTE DEBE DE PROPORCIONAR VERIFICACION DE CIUDADANIA DE LOS ESTADOS UNIDOS.

Favor de seleccionar uno:

_____ He leído las preguntas anteriores y respuestas. Declaro bajo pena de castigo y perjurio, bajo las leyes del Estado de California, que lo anterior es verdad y correcto al mejor de mi conocimiento. **{O}**

_____ Me es imposible leer las preguntas anteriores y respuestas, pero alguien mas me las ha leído en mi idioma natal. Declaro bajo pena de castigo y perjurio, bajo las leyes del Estado de California, que las respuestas que me fueron leídas son verdad y correctas al mejor de mi conocimiento.

Ejecutado este día _____ de _____, 2008, en _____ _____ [ciudad, estado]

Firmado por: _____
Firma del Traductor (si hay alguno) _____

COUNTY OF SAN DIEGO – COUNTY MEDICAL SERVICES
Application for County Medical Services Hardship

This application is necessary to apply for a County Medical Services (CMS) Hardship. Complete this form only if your income in the month you applied was more than 165% of the Federal Poverty Level. Only you or your authorized representative can sign this application under penalty of perjury.

Information from your initial CMS application will be used to evaluate this CMS Hardship Application. However, additional information may be needed to complete this evaluation. All of the information requested in this application is voluntary but failure to completely and accurately provide the information may result in a denial of this CMS Hardship Application. Errors or omissions in the information provided by you that would affect the County's decision may also be a basis for denial of the request for CMS eligibility.

Eligibility for CMS shall not be granted if it is determined that you willfully submitted incorrect information to be used for determining eligibility for public assistance.

APPLICANT INFORMATION:

Applicant's Name (First, Middle, Last): Social Security Number: Birth Date (m/d/y):

PLEASE COMPLETE THE INFORMATION BELOW FOR COUNTY MEDICAL SERVICES HARDSHIP.

A. APPLICANT'S MONTHLY EXPENSES DURING THE MONTH YOU APPLIED FOR CMS: If monthly expenses exceed monthly income, an explanation must be provided (please attach separately):

Mortgage/Rent. Attach copies of receipt(s), cancelled check(s), monthly bill(s), or other evidence of amounts paid during claim period if not previously provided.	$_____
Utilities. Attach copies of receipt(s), cancelled check(s), monthly bill(s), or other evidence of amounts paid during claim period if not previously provided.	$_____
Transportation Expenses (Include car payments, auto insurance, gas, maintenance costs and/or public transportation costs). Attach copies of receipt(s), cancelled check(s), monthly bill(s), or other evidence of amounts paid towards car loans and auto insurance during claim period if not previously provided.	$_____
Food.	$_____
Miscellaneous -- Clothing and personal care -- Household Expenditures -- Telephone	$_____
Taxes (Actual State, Federal, Social Security, Medicare, and State Disability Insurance paid on wages). Attach copies of payroll information evidencing amounts paid during claim period if not previously provided.	$_____
Court Ordered Alimony/Child Support. Attach copy of court order for claim period if not previously provided.	$_____
Payments on previous Medical Debt. Attach copy of payment agreements applicable during claim period, or other documents showing payment.	$_____
TOTAL MONTHLY EXPENSES	$_____

Provide the information requested even if you no longer have receipts or other documents that show your actual expenses. You will sign this application under penalty of perjury. If you do not remember the month you applied for CMS, call the County at 1-800-587-8118 for the information.

CERTIFICATION

I understand that the statements I have made on this application are subject to investigation and verification. I declare under penalty of perjury, that the statements I have given on this form, to the best of my knowledge, are true and correct.

Print or Type Full Name	( ) Telephone Number
Signature of Applicant (person applying for CMS Hardship)	Date
Print or Type Full Name	( ) Telephone Number
Signature of Person Completing Form (If different from above)	Date

PRIVACY STATEMENT

The Information Practices Act of 1977 (California Civil Code, section 1798.1, et. seq.) and the Federal Privacy Act of 1974 (Title 5, United States Code, section 552a, et. seq.) require that this notice be provided when collecting personal information from individuals.

The County of San Diego, Health and Human Services Agency is seeking the information requested on the CMS Hardship Application. The person responsible for the system of records for information obtained from the application is the Deputy Director of Strategic Planning and Operational Support, 1700 Pacific Highway, San Diego, CA 92101.

This information is being collected pursuant to the authority granted to the County by Welfare & Institutions Code, section 17000, et. seq.

All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the CMS Hardship Application. The principle purpose for which the information will be used is to assess an applicant's financial and medical conditions, to determine if hardship criteria apply to the applicant, and to verify information stated in the application in an effort to circumvent any form of fraud against the County Medical Services program.

The County does not have any known or foreseeable disclosures that may be made of the information, other than as necessary to medical providers to confirm eligibility. The applicant has a right of access to records containing personal information maintained by the County.

CONDADO DE SAN DIEGO – COUNTY MEDICAL SERVICES
Solicitud por Circunstancia Extrema de CMS

Es necesario presentar esta solicitud para solicitar la Circunstancia Extrema del programa County Medical Services (CMS). Complete esta forma únicamente si su ingreso fue más alto de 165% del Nivel de Pobreza Federal FPL en el mes de la solicitud. Sólo el solicitante o un representante autorizado del solicitante puede firmar esta solicitud bajo pena de sanción por perjurio.

La información que se encuentra en la solicitud para el programa CMS se usará para evaluar la solicitud por Circunstancia Extrema del programa CMS; si es necesario, se le pedirá información adicional. Toda la información que se pide en esta solicitud es voluntaria. El no proporcionar información correcta y precisa puede resultar en que se le niegue la solicitud por Circunstancia Extrema del programa CMS. Cualquier error u omisión en la información proporcionada por el solicitante, puede afectar la decisión del Condado y puede ser una base para negar la solicitud por Circunstancia Extrema del programa CMS.

No se otorgará la Circunstancia Extrema de CMS si se determina que el solicitante ha proporcionado de manera intencional información incorrecta con el propósito de afectar la determinación de elegibilidad para asistencia pública.

INFORMACION DEL SOLICITANTE:

Nombre del Solicitante (Primero, Segundo, Apellido): Número de Seguro Social: Fecha de Nacimiento (m/d/a):

POR FAVOR COMPLETE LA INFORMACION ABAJO PARA LA CIRCUNSTANCIA EXTREMA DEL PROGRAMA SERVICIOS MEDICOS DEL CONDADO (CMS).

A. GASTOS MENSUALES DEL SOLICITANTE. POR EL MES QUE SOLICITO EL CMS.

Si los gastos mensuales exceden el ingreso mensual, debe proveer una explicación (por favor adjunte por separado):

Hipoteca/Renta. Adjunte una copia de la cantidad pagada si no se proporcionó anteriormente.	$_____
Utilidades. Adjunte una copia de la cantidad pagada si no se proporcionó anteriormente.	$_____
Gastos de Transporte (Incluya pagos de auto, seguro de auto, gasolina, costos de mantenimiento y/o de transporte público). Adjunte una copia de la cantidad pagada si no se proporcionó anteriormente.	$_____
Comida	$_____
Gastos Misceláneos: -- Ropa y cuidado personal -- Gastos del Hogar -- Teléfono	$_____
Impuestos (Impuestos Estatales, Federales, del Seguro Social, Medicare, y Seguro del Estado por Incapacidad (SDI) actuales pagados por sueldo e ingreso). Adjunte una copia de la cantidad pagada si no se proporcionó anteriormente.	$_____
Pagos por una Deuda Médica anterior. Adjunte una copia del acuerdo de pagos o un comprobante de pago.	

CERTIFICACIÓN

Entiendo que todas las declaraciones que hice en esta solicitud se sujetarán a investigación y verificación. Declaro bajo pena de perjurio que las declaraciones que he dado en este formulario son verdaderas y correctas hasta el límite de mi entendimiento.

Nombre Completo Escrito a Mano o a Máquina	( ) Número de Teléfono
Firma del Solicitante (persona solicitando para la Circunstancia Extrema del Programa CMS)	Fecha
Nombre Completo Escrito Mano o a Máquina	( ) Número de Teléfono
Firma de la Persona que Completó Este Formulario (si es diferente de arriba)	Fecha

ESTADO DE PRIVACIDAD

Acto de Información Practicantes de 1977 (California Civil Code, section 1798.1, et. seq.) y Acto Federal de Privancia de 1974 (Title 5, United States Code, section 552a, et. seq.) requiere que esta noticia sea proporcionada cuando se colecta información personal de individuos.

Agencia de Salud y Servicios Humanos del Condado de San Diego esta solicitando información que se pide en la aplicación de Circunstancia Extrema del programa CMS. La persona responsable del sistema de documentos para la información obtenida por medio de la solicitud es el Deputa Director of Strategic Planning and Operational Support, 1700 Pacific Highway, San Diego, CA 92101.

Esta información se esta colectando conforme a la autoridad concedido al Condado por el Código de Bienestar y Instituciones, sección 17000, et. seq.

Toda la información que se pide en esta solicitud es voluntaria, sin embargo, si no proporciona información completa y verdadera puede que se le niegue la solicitud de Circunstancia Extrema del programa CMS. La intención principal que esta información será usada será para tener acceso de las condiciones financieras y medicas del solicitante, determinar si el criterio aplica a la circunstancia extrema aplica al solicitante, y para verificar la información declarada el la solicitud con el intento de evadir cualquier tipo de fraude contra el programa de Servicios Médicos del Condado.

El Condado no tiene ningún o previsible revelación que se pueda haber hecho de esta información, aparte de la necesidad para que los proveedores médicos confirmen elegibilidad. El solicitante tiene el derecho de obtener acceso de los documentos que contiene información personal mantenido por el Condado.

CMS LAWSUIT CLAIMANT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby voluntarily authorize
(NAME OF CLAIMANT)

_____ to release information to
(NAME OF COLLECTION AGENCY)

San Diego County Medical Services (CMS) and the CMS Administrative Services Organization, AmeriChoice, which is needed by AmeriChoice to accurately calculate and pay out monies owed to the claimant and/or a health care provider of the claimant.

****

- I understand that my personal health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- I understand that I may withdraw and/or change this Authorization at any time, except to the extent that action has already occurred. I understand if I withdraw this authorization, I must do so in writing.
- I have the right to request in writing a copy of information being disclosed.
- If I am unable to sign this Authorization, a legal guardian or other person with lawful authority to act on my behalf can sign on my behalf; and has the right to receive a copy of the signed Authorization.
- I am entitled to a copy of this Authorization, if I request one.
- This Authorization expires 12 months from the initial signing date below.

I HAVE READ THIS FORM AND AGREE TO THE DISCLOSURE ABOVE.

APPLICANT'S NAME (PRINT)	APPLICANT'S SSN
APPLICANT'S SIGNATURE	DATE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR APPLICANT	DATE SIGNED
PRINT NAME OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR APPLICANT	RELATIONSHIP TO APPLICANT

AUTORIZACION PARA PROPORCIONAR INFORMACION DEL RECLAMANTE DE LA DEMANDA COLECTIVA DE CMS

Yo, _____por este medio autorizo voluntariamente a
(NOMBRE DEL RECLAMANTE)

_____ que otorgue información al programa de
(NOMBRE DE LA AGENCIA DE COLLECCION)
County Medical Services (CMS) del Condado de San Diego y la Organización Administrativa de Servicios de CMS, AmeriChoice, que es necesaria para AmeriChoice calcular exactamente la cantidad de dinero debido al reclamante y/o al proveedor de salud.

- Entiendo que mi información de salud personal será revelada de acuerdo con esta autorización y puede ser sujeta a revelarse de nuevo al destinatario y ya no será protegida por las regulaciones de privacidad federal.
- Entiendo que puedo retirar y/o cambiar esta Autorización en cualquier tiempo, con excepto a acción que ya haya sido ocurrido. Entiendo que si retiro esta autorización, debo de hacerlo por escrito.
- Tengo el derecho de solicitar por escrito una copia de la información revelada.
- Si estoy incapaz de firmar esta autorización, un representante legal u otra persona con autoridad legal que actúe de mi parte y que firme por mi parte, tiene derecho de recibir una copia de esta autorización firmada.
- Tengo el derecho de recibir una copia de esta autorización, si la solicito.
- Esta autorización se vence después de 12 meses de la fecha firmada abajo.

YO HE LEIDO ESTA FORMA Y ESTOY DE ACUERDO CON LA REVELACION ANOTADA ARRIBA.

NOMBRE DEL SOLICITANTE (LETRA DE MOLDE)	NUMERO DEL SEGURO SOCIAL DEL SOLICITANTE
FIRMA DEL SOLICITANTE	FECHA
FIRMA DEL TESTIGO SI FIRMA CON UNA MARCA, INTERPRETE, O PERSONA QUE ACTUA COMO EL SOLICITANTE	FECHA
NOMBRE EN MOLDE DEL TESTIGO SI FIRMA CON UNA MARCA, INTERPRETE, O PERSONA QUE ACTUA COMO EL SOLICITANTE	RELACION AL SOLICITANTE

COUNTY MEDICAL SERVICES

INFORMATIONAL NOTICE: THE COUNTY'S LEGAL RIGHTS AND LIMITATIONS ON REPAYMENT

The following sections of the Welfare & Institutions Code may apply to the lien and repayment agreement: §17109, §17400, §17401, §17402, §17403, §17403.1, §17404, §17405, §17406, §17407, §17408, §17409.

You can read more about these sections at: http://www.leginfo.ca.gov/calaw.html

If you have questions, contact Western Center on Law and Poverty toll-free at 1-800-405-8759 or by mail at:

Western Center on Law and Poverty
Attn: CMS Repayment
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

COUNTY MEDICAL SERVICES

AVISO INFORMATIVO:
DERECHOS LEGALES DEL CONDADO Y LAS LIMITACIONES DEL REEMBOLSO

Las siguientes secciones del Código Welfare & Institutions pueden aplicarse al acuerdo del gravamen y reembolso: §17109, §17400, §17401, §17402, §17403, §17403.1, §17404, §17405, §17406, §17407, §17408, §17409.

Usted puede leer más sobre estas secciones en: http://www.leginfo.ca.gov/calaw.html

Si tiene preguntas, póngase en contacto con el Centro Western en Ley y Pobreza llamando al 1-800-405-8759 (llamada gratuita) o por escrito a:

Western Center on Law and Poverty
Attn: CMS Repayment
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010